US and UK health care: a special relationship?
Money can't buy you satisfaction

Chris Ham

Organisational differences between the US and UK healthcare systems mean that ideas have to be adapted through learning partnerships rather than simply copied

The NHS performs as well as or better than the US healthcare system on many objective indicators. Yet the United Kingdom shows greater interest in learning from the United States than vice versa. Is this paradox a consequence of American insularity, British credulity, or some other factor? And is there any prospect of the balance of trade in health policy ideas being reversed? If so, what aspects of health care in the United Kingdom should the United States be studying and seeking to learn from?

Comparing the two systems

Take the facts first. The United States spends almost 15% of gross domestic product on health care[1] compared with less than 8% in the United Kingdom.[2] Population health as measured by infant mortality and life expectancy are broadly comparable in the two countries and lag behind those achieved in high performing systems like Japan and Sweden.[3] Although the majority of the public in both the United Kingdom and United States express dissatisfaction with their healthcare systems, a higher proportion of the British population think their system works well, and a lower proportion believe the system needs to be rebuilt completely, than in the United States.[4]

Around 45 million Americans under the age of 65 lack health insurance cover, and far more US citizens than UK citizens report that the cost of health care is a barrier to access. In a five nation survey that included Britain and the United States, Britain performed best in offering health care that was equitable, even though waiting times for treatment were the longest.[5] A study of the quality of medical care in different countries found the United States performing relatively well, although the authors noted that in view of the much higher levels of expenditure "it is difficult to conclude that it is getting good value for its medical dollar."[6] An overall assessment made by the World Health Organization in its hotly contested ranking of countries in terms of health system performance placed the United Kingdom 18th and the United States 37th out of 191 countries studied.[7]

This suggests that as a system the achievements of the United States do not match those of the United Kingdom, even though the United States contains many examples of clinical excellence and provides highly responsive care to people who are insured.

Lessons taken from the United States

In the light of these facts, it is paradoxical that UK interest in learning from the United States is greater than the other way round. Evidence of this learning is to be found everywhere. Back in the 1980s, the Thatcher government drew on ideas advocated by the Stanford economist, Alain Enthoven, in formulating its plans for an internal market for the NHS.[8] More recently, the Blair government's reforms to the NHS have led to a renewed interest in importing policies from across the Atlantic, most obviously in the introduction of a new system for paying hospitals that draws heavily on the use of prospective payment in the United States.

Another example of learning from the United States can be found in the NHS policy on chronic disease. Partnerships have been created with organisations such as Kaiser Permanente and United Healthcare with a track record of innovation in managing chronic conditions (see bmj.com). These partnerships are focusing on the adaptation by the NHS of managed care techniques like case management, risk stratification, and predictive modelling. By comparison, the United States has shown little interest in learning from Britain, even though a steady stream of scholars over the years has studied the NHS and drawn attention to its achievements.[9]

This is the second in a series of articles in which we asked experts in UK and US healthcare systems to identify opportunities for learning between the two countries

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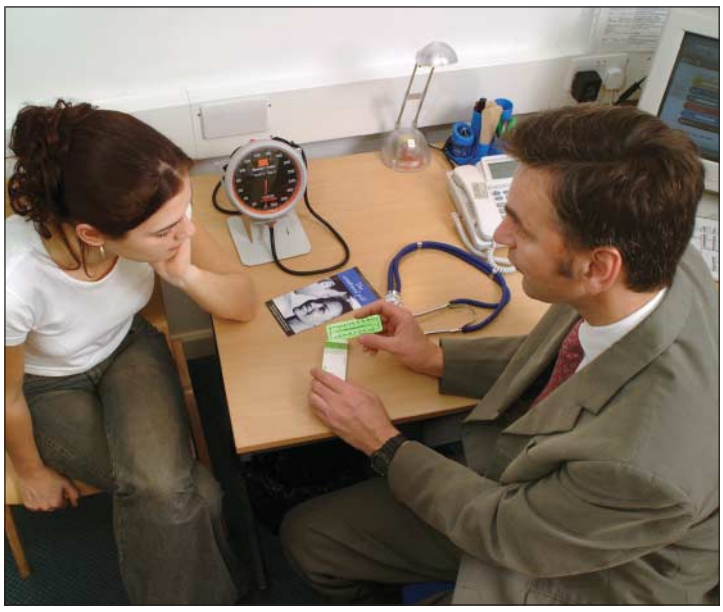
P+ *Further explanation of some of the learning opportunities is on bmj.com*



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UK primary care offers many lessons for the United States

Explaining the paradox

How can this paradox be explained? A large part of the answer is to be found in the difficulty of exporting British experience to the United States because of fundamental differences in values and politics. Overcoming the gaps in insurance coverage and financial barriers to accessing care that most distinguish the United States from Britain would require a radical transformation of health financing of the kind that has previously proved impossible to achieve. Such a transformation would entail a shift from a mixed system of financing in which employment based insurance predominates to either a tax funded or social insurance based system that in most other developed countries has guaranteed all citizens access to necessary medical care.

In a society that is distrustful of government and that holds dear to personal freedom and choice, it is hard to conceive of the circumstances in which a shift of this magnitude might occur. As Robinson, one of the most acute observers of the US healthcare system, has noted:

> The American people want to direct their own health care, with clinical advice from their physicians, financial subsidy from employers and public programs, information from the Internet and offline sources, and the support of their families and friends. Public health insurance initiatives will expand to the extent private initiatives contract, but the likelihood of a national, one-size-fits-all programme becomes more remote with each passing year.[10]

Differences in values and politics present much less of a barrier to the United Kingdom importing ideas from the United States because the lessons on offer do not require wholesale restructuring of the NHS. Rather, as policy makers in successive British governments have discovered, it is possible to cherry pick initiatives from the US healthcare system in a pragmatic and often incremental fashion. Changing values in British society have assisted in this process by creating a context that is more receptive to the transfer of American experience.

Most obviously, the desire of the Blair government to modernise public services through introducing greater elements of choice for users and competition between providers has made the United States a promising source of ideas for those undertaking reform. This is because the reliance on market principles in US health care has created an enormous laboratory for experimentation and innovation, enabling policy makers in Britain to draw selectively from US experience in support of a comprehensive and wide ranging reform programme. The ideas borrowed have often been moulded to fit the UK context, and the resulting hybrids may differ appreciably from their origins.

What might the United States learn from Britain?

Is there any prospect of the balance of trade in health policy ideas being reversed? If radical transformation of the financing of US health care is unlikely, several other NHS initiatives have the potential to contribute to the reform of the US healthcare system. Starfield's research has shown that countries whose healthcare systems have a strong primary care orientation tend to perform better than those that lack this orientation. In the comparative studies undertaken by Starfield and colleagues, the United Kingdom emerges as the country that has made most progress in developing provision of primary care, and this is one factor that explains why it is able to deliver universal and comprehensive health care for a much lower level of spending than the United States.[11]

The changes currently taking place to the general practitioners' contract, including the use of financial incentives to raise standards of care, are intended to build on the strengths of British primary care and to reward quality of service and not just the quantity of care provided.[12] Interesting parallels exist with initiatives taking place in the United States designed to link payment to performance,[13] suggesting that the experience of the new contract may be a potential export from the United Kingdom, even if a primary care gatekeeping system is unlikely to fit with US values. The focus of the quality payments on the treatment of common chronic conditions, which are an equal challenge for the United States and the United Kingdom, underlines the scope for learning in this area.

Another initiative with the potential to travel is the work being done in the NHS to promote quality and safety. This encompasses the preparation of national service frameworks for major clinical priorities such as coronary heart disease and diabetes and the publication of guidelines on the use of new drugs and other technologies based on analyses by the National Institute for Clinical Excellence. Other initiatives include the National Patient Safety Agency (set up to run a mandatory reporting system for logging all failures and errors and promote a culture of safety), the duty of clinical governance placed on all NHS organisations, and the establishment of the Healthcare Commission to inspect providers and report on their performance. A major investment is also being made in information technology, including the development of an electronic health record.

The activities that have been set in train in the NHS do not yet represent a completely coherent and focused programme on quality and safety, but they have provided a strong basis for further development. This was recognised in the review commissioned by the Nuffield Trust that described the programme as, "The world's most ambitious, comprehensive, systemic and intentionally funded effort to create predictable and sustainable capacity for improving the quality of a nation's health care system."[14] The United Kingdom can fairly claim to be at the forefront of countries seeking to bridge the quality chasm identified by the Institute of Medicine in its landmark report of the same name.[15] Its experience deserves careful study by US policy makers concerned to reduce errors and narrow the gap between best practice and actual practice shown by research published in 2003.[16]

Summary points

Differences in values and politics make it difficult for the United States to adapt policy ideas from the United Kingdom

The United Kingdom, by contrast, has been able to cherry pick ideas from the United States

The United States can learn from UK initiatives to pay general practitioners to raise standards of care and to promote quality and safety of health care

Both countries can learn from experience in other healthcare systems

Multilateral rather than bilateral learning

In a world where trade barriers are tumbling and borders are opening up, the special relationship between the United States and the United Kingdom should not blind these two countries to the opportunities for learning from elsewhere. As the Commonwealth Fund's survey of quality of care and outcomes in five countries has shown, no country is superior in all areas of performance, and each can learn from others.[6] The United Kingdom has recognised the value of learning from other countries in several policy areas, including adaptation of the system used in Nordic countries for billing local authorities for the cost of keeping patients in hospital when they are ready to be discharged.

Multilateral learning needs to look beyond health systems and identify those elements of each system that repay attention. To use a quite different example, the quest for excellence in motor car production focuses not on countries that have superior performance but rather on firms and plants with a reputation for quality and value for money. By extension, comparative health policy analysis needs to identify and analyse high performing organisations within systems. This has started to happen in the research carried out into organisations like Kaiser Permanente[17 18] and the Veterans Health Administration,[19] and the next phase of cross-national learning and analysis is likely to benefit from more studies of this kind in other countries.

Conclusion

At a time when the NHS is no longer seen as the envy of the world and the US claim to have the best medical care in the world is difficult to sustain, both countries have an interest in learning from each other as well as from others. The process of learning is as much about adaptation as transfer, with policy makers moulding ideas and innovations to fit different cultures and values.[20] Learning will be enhanced by the inclusion of multiple systems and a focus on high performing organisations within systems.

Contributors and sources: This article draws on CH's experience as a health policy researcher and, between 2000 and 2004, as a senior policy maker in the Department of Health in London. It incorporates ideas discussed in various meetings that have brought together researchers and policy makers from the United States and the United Kingdom and the author's research comparing aspects of health systems performance in the two countries. It has benefited from comments made on earlier drafts by colleagues in both countries.

Competing interests: CH is working with the NHS Modernisation Agency in seeking to adapt aspects of Kaiser Permanente's approach to the management of care in the NHS in England.

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